

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012076

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 231

Primary Registration District No. 3048

Registrar's No. 78

FILED MAR 19 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|--------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Nodaway</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Maryville</u> | | c. CITY OR TOWN <u>Maryville</u> | |
| Length of stay in 1b <u>4 days</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF DECEASED (If not in hospital, give location) <u>St Francis Hosp.</u> | | d. STREET ADDRESS (If outside, give location) <u>Maryville</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>H.</u> Last <u>Roney</u> | | 4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1962</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Cau</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-12-1891</u> |
| 9. AGE (last birthday) <u>70</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Stockman</u> | | 11. BIRTHPLACE (City and state or country) <u>Quitman, Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Peter F. Roney</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Agnes Scanlan</u> | | 15. NAME OF HUSBAND OR WIFE <u>Margaret Roney</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes <input type="checkbox"/> or unknown) (If yes, give war or dates of service) <u>No</u> | | 17. SOCIAL SECURITY NO. <u>197 Mrs Margaret Roney</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | |
| PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION <u>3-4-62</u> to <u>3-8-62</u> and last saw him alive on <u>3-8-62</u> | |
| 21. I attended the deceased from <u>3-4-62</u> to <u>3-8-62</u> and last saw him alive on <u>3-8-62</u> | | Death occurred at <u>3:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE <u>James W. P.</u> (Degree or title) | | 22b. ADDRESS <u>Maryville Mo</u> | |
| 22c. DATE SIGNED <u>3-9-62</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE <u>3-12-1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's</u> | |
| 23d. LOCATION (City, town, or county) <u>Maryville Mo.</u> | | 23e. DATE RECD. BY LOCAL REG. <u>3-12-62</u> | |
| 23f. REGISTRAR'S SIGNATURE <u>Bess Holt</u> | | 23g. FUNERAL DIRECTOR <u>Hitchison - Maryville, Mo</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

G. M. Atchison

Licensed Embalmer No. 2279

P. O. Address

Maryville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.